MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02276 02272

1. DECEASED NAME (Type or print): First PAUL Middle JAMES Last ARNDT
2a. DATE OF DEATH: Month February Day 7 Year 1969
2b. HOUR: 6:25 P.M.
3. SEX: Male
4. RACE: White
5. DATE OF BIRTH: 10-21-46
6. AGE (In years last birthday): 22 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (State or foreign country): Maryland
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
9. COUNTY OF DEATH: Cecil Md.
10. CITY OR TOWN OF DEATH: Perry Point
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Veterans Administration
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Chemical Technician
12b. KIND OF BUSINESS OR INDUSTRY: Chem. Plant
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md
13b. COUNTY: Harford
13c. CITY OR TOWN: Aberdeen
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: 629 Walker Street
14. FATHER'S NAME First Middle Last: Paul W. Arndt
15. MOTHER'S MAIDEN NAME First Middle Last: Lucille J. Albano
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service): yes PL-90
16b. SOCIAL SECURITY NO.: 215-48-3971
17. INFORMANT Address: VA Records, VAH, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Malignant Cachexia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF
(b) Sarcoma of left upper arm with generalized — 15 Months
DUE TO, OR AS A CONSEQUENCE OF
(c) metastasis

1737
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☒ NO ☐
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from 1-31, 1969, to 2-7-, 1969, that (I) (we) last saw the deceased alive on 2-7-69 19___, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: A. L. Mooney, M.D. DEGREE ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22c. DATE SIGNED: 2-8-69
22d. PHYSICIAN'S NAME (Type): A. L. MOONEY, M.D.
22e. ADDRESS: VAH, Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 12-Feb.1969
23c. NAME OF CEMETERY OR CREMATORY: Harford Memorial Gardens
23d. LOCATION (City or Town) (County) (State): Aberdeen, (Harford) Maryland
24. FUNERAL DIRECTOR ADDRESS: JOHN G TARRING 333 S.Parke St Aberdeen,Md
25a. REC'D BY REGISTRAR DATE: FEB 10 1969
25b. REGISTRAR'S SIGNATURE: Wilmalee Yeager

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M - 1X69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02277 02273

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First / Middle / Last	George Edward Atkinson			2a. DATE OF DEATH Month / Day / Year	Feb. 25 1969
				2b. HOUR	1030 P.M.
3. SEX	Male	4. RACE	White	5. DATE OF BIRTH	April 5, 1893
6. AGE (In years last birthday)	75 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS.: HOURS / MIN	
7a. BIRTHPLACE (State or foreign country)	Maryland	7b. CITIZEN OF WHAT COUNTRY?	USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐	
9. COUNTY OF DEATH	Cecil Md.				
10. CITY OR TOWN OF DEATH	Elkton	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	Union Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	Herdsman
12b. KIND OF BUSINESS OR INDUSTRY	Farming				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	Maryland	13b. COUNTY	Cecil	13c. CITY OR TOWN	North East
13d. INSIDE CITY LIMITS?	YES ☐ NO X	13e. STREET AND NUMBER	R.D. # 1		
14. FATHER'S NAME First / Middle / Last	William T. Atkinson	15. MOTHER'S MAIDEN NAME First / Middle / Last	Bertha Rutter		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	No	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Mrs. Mary C. Rawson
Address	Newark, Del.				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) BRAIN DAMAGE - ANOXIA — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

DUE TO, OR AS A CONSEQUENCE OF

(b) CEREBROVASCULAR ACCIDENT — 2 weeks

DUE TO, OR AS A CONSEQUENCE OF

(c) GENERALIZED ARTERIOSCLEROSIS — ? Years

4369

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

BENIGN PROSTATIC HYPERTROPHY - SUPRAPUBIC PROSTATECTOMY - 2-13-69

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO X	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** that (I) (this hospital) attended the deceased from 2-4, 1969, to 2-25, 1969, that (I) (we) last saw the deceased alive on 2-25 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	John A. Najera M.D.	DEGREE	ATTENDING PHYS. ☒	MED DIRECTOR ☐	STAFF PHYS. ☐
22c. DATE SIGNED	2-26-69				
22d. PHYSICIAN'S NAME (Type)	Rolando A. Najera	22e. ADDRESS	105 E. Main St.	Elkton, Md.	

23a. BURIAL, CREMATION, REMOVAL (Specify)	Burial	23b. DATE	2-28-69	23c. NAME OF CEMETERY OR CREMATORY	St. Marks Cemetery
23d. LOCATION (City or Town) (County) (State)	Perryville Cecil Md.				
24. FUNERAL DIRECTOR	Grant Funeral Home	ADDRESS	North East, Md.	25a. RECD BY REGISTRAR DATE	FEB 28 1969
25b. REGISTRAR'S SIGNATURE	Charles Judge				

VR A15 (1) 45M - 1/68

Items 21&22a Film 409
2-24-69 ams

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02278 02274

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
Clara	R.	Benjamin	Feb.	10,	1969	M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS HOURS	MIN
Female	Cau.	November 14, 1877	91 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
Maryland	USA		Cecil Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Rising Sun	10 Walnut Street	House wife	———

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER
Maryland	Cecil	Port Deposit		R.F.D. #1

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Thomas	Miller	Jackson	Maria		Dennison

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	———	215-54-2547	Elsie B. Kennard	Rising Sun, Maryland.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Fractured skull	20 minutes
DUE TO, OR AS A CONSEQUENCE OF (b)	arteriosclerosis cerebral	5 yrs.
DUE TO, OR AS A CONSEQUENCE OF (c)		

880 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)
	10 A.M. 2 10 1969	Fell down stairs

21d. INJURY OCCURRED While at work ☐ Not while at work ☒	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
	Home	Walnut St.	Rising Sun	Cecil	Md.

22a. **I certify** that (I) (this hospital) attended the deceased from 6-10 ——, 19 65, to 2-10 ——, 19 69, that (I) (we) last saw the deceased alive on 6-10 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. Accident

22b. SIGNATURE	DEGREE	ATTENDING PHYS ☒	MED. DIRECTOR ☐	STAFF PHYS. ☐	22c. DATE SIGNED
Neil R. Taylor Jr. M.D.					2-10-69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Neil R. Taylor Jr. M.D.	17 Haines Ave., Rising Sun, Maryland.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
Burial	2/13/1969	Hopewell Cemetery	Port Deposit	Cecil	Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REGISTRAR	25b. REGISTRAR'S SIGNATURE
Lee A. Patterson & Son	Perryville, Md.	DATE FEB 14 1969	

VR A15 (1)
45M - 1-68

1

FOR STATE HEALTH DEPT.

Items7&8 FilmG410 3/5/69kk

Items 18-22aFilm411 4-16-69ams

02275

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02275

1. DECEASED-NAME (Type or Print) First	Middle	Last	2a. DATE KNOWN OF DEATH ESTIMATED	Month	Day	Year	2b. HOUR
CLARA	B.	BLACKSTON	☒ / ☐	2	18	1969	11:47a

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR: MONTHS	DAYS	IF UNDER 24 HRS.: HOURS	MIN	2c. DATE PRONOUNCED DEAD: Month	Day	Year	2d. HOUR
Female	Colored		38 YRS.					February	18	1969	11:47a

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Delaware	USA		Cecil Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during mast of warking life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Elkton	Union Hospital		

13a. USUAL RESIDENCE (Where deceased lived, if institutian: Residence before admissian) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET AND NUMBER
Del.		Middleton		412 N. Cox St.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Walter		Bordley	Ella		Bordley

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
	221-18-6883	Harry H. Blackston-Middletown,Del.	412 N.Cox St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiovascular collapse during

DUE TO, OR AS A CONSEQUENCE OF

(b) anesthesia for abdominal hysterectomy

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditians, if any, which gave rise to immediate cause (a), stating the underlying couse last. 9301

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
2/18/69	Abdominal hysterectomy	YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
	? 2-18 1969	Above

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e. PLACE OF INJURY (At home, farm, street, factary, affice building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
	Hospital	Union Hospital		Cecil	Md.

22a. **I certify** that I took charge of the remains described above, held an Autapsy ☒ Inspectian ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Hamicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Edward F. Wilson M.D.

EXAMINER'S NAME (Type) Edward F. Wilson, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
ADDRESS(Street, city, town, or county)

22b. DATE SIGNED 2/19/69

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	2/22/69	Dale Cemetery	Middletown,Del.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Calvin R. Bell	909 Poplar St.	FEB 26 1969	Florence Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death unless any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

61 46 3 1 1 5 07 2

VR A15ME (5) 10M REV. 1/68

1

02280 MARYLAND STATE DEPARTMENT OF HEALTH 02276

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First: Calvin Middle: W Last: Butler
2a. DATE OF DEATH Month: February Day: 22, Year: 1969
2b. HOUR: 5:25 a.M.
3. SEX: Male
4. RACE: White
5. DATE OF BIRTH: August 25,1896
6. AGE (In years last birthday): 72 YRS. IF UNDER 1 YEAR: MONTHS / DAYS. IF UNDER 24 HRS: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): Easton,Md
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
9. COUNTY OF DEATH: CECIL Md.
10. CITY OR TOWN OF DEATH: Perry Point
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): VA HOSPITAL
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): R.R.Brakeman
12b. KIND OF BUSINESS OR INDUSTRY:
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: VIRGINIA
13b. COUNTY: /
13c. CITY OR TOWN: Cape Charles
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: 525 Monroe Avenue
14. FATHER'S NAME First Middle Last: Frank Butler
15. MOTHER'S MAIDEN NAME First Middle Last: Laura Etta Butler
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: Yes (If yes give war or dates of service): WW I
16b. SOCIAL SECURITY NO.: 217-54-7556
17. INFORMANT Address: VA HOSPITAL RECORDS, Perry Point, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bacterial Septicemia and Toxemia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 days

5901

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(b) Pyelonephritis and cystitis
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) VA
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from Oct. 16, 1928 to Feb. 22, 1969 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (XX) (we) (did) (XXXXX) view the body after death.

22b. SIGNATURE [signature] M.D. DEGREE — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22c. DATE SIGNED: 2-22-69
22d. PHYSICIAN'S NAME (Type): RUSSELL E. MORRIS, JR.
22e. ADDRESS: VA HOSPITAL, Perry Point, Maryland
23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 2-22-69
23c. NAME OF CEMETERY OR CREMATORY: Greensboro Cemetery
23d. LOCATION (City or Town) (County) (State): Greensboro, Md
24. FUNERAL DIRECTOR: [signature] John E. Boulais — Rawlings-Boulais ADDRESS: Greensboro, Md.
25a. REC'D BY REGISTRAR DATE: FEB 27 1969
25b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02281 — 02277

1

1. DECEASED-NAME (Type or print): First: Ralph; Middle: William; Last: Carr Sr.
2a. DATE OF DEATH: Month: Feb; Day: 25; Year: 1969
2b. HOUR: 3Ø M
3. SEX: Male
4. RACE: White
5. DATE OF BIRTH: Jan. 1, 1911
6. AGE (In years last birthday): 58 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (State or foreign country): Md.
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
9. COUNTY OF DEATH: Cecil Md.
10. CITY OR TOWN OF DEATH: Conowingo R.F.D.
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Conowingo R.F.D.
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Laborer
12b. KIND OF BUSINESS OR INDUSTRY: Stone Quarry
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.
13b. COUNTY: Cecil
13c. CITY OR TOWN: Conowingo
13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET AND NUMBER: R. F. D.
14. FATHER'S NAME: First: William; Middle: Pussey; Last: Carr
15. MOTHER'S MAIDEN NAME: First: ; Middle: ; Last: Harman
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16b. SOCIAL SECURITY NO: 218-05-9402
17. INFORMANT (Son): Address: Ralph W. Carr Jr. Same as Above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infartion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO, OR AS A CONSEQUENCE OF
(b): Two previous infarctions in two months
DUE TO, OR AS A CONSEQUENCE OF
(c): Arteriosclerotic heart disease — 5 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1107

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from 11-1, 1968, to 2-25, 1969, that (I) (we) last saw the deceased alive on 2-25 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Neil R Taylor — DEGREE: ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: 2-27-69
22d. PHYSICIAN'S NAME (Type): Neil R. Taylor Jr.
22e. ADDRESS: Rising Sun, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 2-28-1969
23c. NAME OF CEMETERY OR CREMATORY: Pleasent Groove Cem.
23d. LOCATION (City or Town) (County) (State): Peachbottem, Lancaster PA.
24. FUNERAL DIRECTOR: Jerome McMullen — ADDRESS: Rising Sun, Md.
25a. RECD BY REGISTRAR DATE: MAR 3 1969
25b. REGISTRAR'S SIGNATURE: Charles Yeager

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02282 02278

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print) First / Middle / Last	WILLIAM THOMAS COLLINS	2a. DATE OF DEATH Month / Day / Year	Feb 3 1969	2b. HOUR	9 00 AM
3. SEX	MALE	4. RACE	WHITE	5. DATE OF BIRTH	OCT. 26, 1881
6. AGE (In years last birthday)	87 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS: HOURS / MIN	
7a. BIRTHPLACE (State or foreign country)	CECIL Md.	7b. CITIZEN OF WHAT COUNTRY?	USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	
9. COUNTY OF DEATH	CECIL Md.				
10. CITY OR TOWN OF DEATH	ELKTON	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	UNION HOSP	12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired)	MACHINIST
12b. KIND OF BUSINESS OR INDUSTRY	TOOL & DYE	13a. USUAL RESIDENCE (Where deceased lived, if institution before admission) STATE	Md	13b. COUNTY	CECIL
13c. CITY OR TOWN	ELKTON	13d. INSIDE CITY LIMITS? YES ☒ NO ☐		13e. STREET AND NUMBER	142 W HIGH ST.
14. FATHER'S NAME First / Middle / Last	WILLIAM V. COLLINS	15. MOTHER'S MAIDEN NAME First / Middle / Last	AMANDA WRIGHT		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)	No	(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.	183-12-0885
17. INFORMANT	MRS. ANNE C. TELASCO	Address	HICKSVILLE L.I., N.Y.		

MEDICAL CERTIFICATION

1B. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Squamous Cell Carcinoma, Skin, Neck — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 year

DUE TO, OR AS A CONSEQUENCE OF With Metastases

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) _____

DUE TO, OR AS A CONSEQUENCE OF

(c) _____

1734

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)		
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY OFFICE BUILDING ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County / State

22a. **I certify** that (I) (this hospital) attended the deceased from 12/25/68, 19 69, to 2/3, 19 69, that (I) (we) last saw the deceased alive on 2/3 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	John A. Fischer	DEGREE	ATTENDING PHYS ☐	MED. DIRECTOR ☐	STAFF PHYS ☐
22c. DATE SIGNED	2/5/69				
22d. PHYSICIAN'S NAME (Type)	JOHN A. FISCHER	22e. ADDRESS	ELKTON Md.		

23a. BURIAL, CREMATION, REMOVAL (Specify)	BURIAL	23b. DATE	FEB. 6, 1969	23c. NAME OF CEMETERY OR CREMATORY	ELKTON CEM
23d. LOCATION (City or Town) (County) (State)	ELKTON CECIL Md				
24. FUNERAL DIRECTOR	PIPPIN FUNERAL HOME	ADDRESS	ELKTON Md.	25a. REC'D BY REGISTRAR DATE	FEB 7 1969
25b. REGISTRAR'S SIGNATURE	Charles Judge				

VS A15 45M 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02283 02279

CERTIFICATE OF DEATH

1 PLACE OF DEATH
a. COUNTY: CECIL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON
c. LENGTH OF STAY IN 1b: 5 WEEKS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): UNION HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: KENT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): KENNEDYVILLE
d. STREET ADDRESS: —
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CLARA — Middle T. — Last COPPER
4. DATE OF DEATH: Month FEB. — Day 4, — Year 1969

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: NOV. 9, 1886
9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: HOME
11. BIRTHPLACE (County & State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ALEXANDER THAWLEY
14. MOTHER'S MAIDEN NAME: VIRGINIA STOREY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes give war or dates of service): —
16. SOCIAL SECURITY NO.: 217-12-4039
17. INFORMANT: WARREN COPPER — Address: KENNEDYVILLE, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): LEFT HEMIPLEGIA — INTERVAL BETWEEN ONSET AND DEATH: 24 hours
DUE TO (b): C.V.A. — 24 hours
DUE TO (c): —
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4369

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): METASTASIS
CARCINOMA OF GALL BLADDER & GENERALIZED
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1/27, 1969 to 2/4, 1969 that (I) (we) last saw the deceased alive on 2/3 1969, and that death occurred at 7:30 A.M. from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): HENRY U. DAVIS MD
22d. ADDRESS: CHESAPEAKE CITY MD

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 2-7-69
23c. NAME OF CEMETERY OR CREMATORY: CHURCHILL CEMETERY
23d. LOCATION (City or Town) (County) (State): CHURCH HILL KENT MD.

24. FUNERAL DIRECTOR: VICTOR N. KENNEDY — ADDRESS: STILLPOND, MD.
25a. REC'D BY REGISTRAR DATE: FEB 7 1969
25b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02284

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02280

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

00 07 1 Male 2 2

1. PLACE OF DEATH
   a. COUNTY: Cecil — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Conowingo
   c. LENGTH OF STAY IN 1b: 6 years
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Rock Springs Rd.

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Cecil
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Conowingo
   d. STREET ADDRESS: Rock Springs Rd.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Robert — Middle: Hayward — Last: Crouse

4. DATE OF DEATH: Month: February — Day: 21 — Year: 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 27,1903

9. AGE (In years last birthday): 65 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Sparta,N.C.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Hillary Crouse

14. MOTHER'S MAIDEN NAME: Lula Mabe

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 219-01-0453

17. INFORMANT — Address: Mrs. Lula Ensign,Conowingo,Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Anoxia — INTERVAL BETWEEN ONSET AND DEATH:

485 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Cardio-Respiratory Failure — 3 days

DUE TO (c): Bronchopneumonia — 7 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour 6:30 a.m. p.m. 2/21/69

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) (County) (State): Conowingo Cecil Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Rolando A. Najera M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED: Feb.22,1969

NAME (Type): Rolando A. Najera, M.D.

Address (Street, city, town, or county):

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Feb.24,1969

23c. NAME OF CEMETERY OR CREMATORY: Conowingo Baptist

23d. LOCATION (City, town or county) (State): Conowingo Cecil Md.

24. FUNERAL DIRECTOR — ADDRESS: JOHN H. HARKINS Delta,Penna.

25a. REC'D BY REGISTRAR DATE: MAR 3 1969

25b. REGISTRAR'S SIGNATURE: Charles Griggs

VR A1SME (5) 5M 1/65

3

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02285

CERTIFICATE OF DEATH

02281

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (Then please remove carbon papers. Pages 2 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chesapeake City
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Charles — Middle Franklin — Last Dixon
4. DATE OF DEATH: Month February — Day 10, — Year 1969

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: February, 4, 1891
9. AGE (In years last birthday): 78 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (County & State, or foreign country): Earleville, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Dixon.
14. MOTHER'S MAIDEN NAME: Jane Williams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If yes give war or dates of service):
16. SOCIAL SECURITY NO: 218-40-1032-A
17. INFORMANT: Mrs. Susan DuBois, Address: Stanton, Del.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CORONARY THROMBOSIS
DUE TO (b): ATRIAL FIBRILLATION
DUE TO (c): CHRONIC CARDIOVASCULAR RENAL DISEASE
4100
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: (a) 1 HR (b) SEVERAL YEARS (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): UREMIA - PROSTATIC OBSTRUCTION

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from FEB 5, 1969 to FEB 10, 1969, that (I) (we) last saw the deceased alive on FEB 10 1969, and that death occurred at 1:24 P.M. from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 2/11/69
22c. PHYSICIAN'S NAME (Type): HENRY J. DAVIS MD
22d. ADDRESS: CHESAPEAKE CITY MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Feb. 13, 1969
23c. NAME OF CEMETERY OR CREMATORY: Olivet Meth. Church Yard.
23d. LOCATION (City or Town) (County) (State): Galena, Kent, Md.

24. FUNERAL DIRECTOR: Edward Fellows & Son, ADDRESS: Millington, Md. 21651
25a. REC'D BY REGISTRAR DATE: FEB 14 1969
25b. REGISTRAR'S SIGNATURE: [signature]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02286 — 02282

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15(2) 30M REV. '66

1. DECEASED-NAME (Type or print) First: Wilbur	Middle: Roy	Last: Forney	2a. DATE OF DEATH Month: Feb. Day: 13 Year: 1969	2b. HOUR: 3 PM	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: May 15, 1885	6. AGE (In years last birthday): 83 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): Penn.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Cecil Md		
10. CITY OR TOWN OF DEATH: Rising Sun, Md.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Calvert Mannor Nursing Home	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Electrician	12b. KIND OF BUSINESS OR INDUSTRY: U.S.Navy		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: Cecil	13c. CITY OR TOWN: Rising Sun	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: Cherry Street	
14. FATHER'S NAME First: Jacob	Middle: —	Last: Forney	15. MOTHER'S MAIDEN NAME First: Margaret	Middle: —	Last: Knell
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No	(If yes give war or dates of service): ---	16b. SOCIAL SECURITY NO.: 201-16-3129	17. INFORMANT: Mrs Walter Cameron	Address: Rising Sun, Md.	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Subdural Hem. auto accident — 4 days

DUE TO, OR AS A CONSEQUENCE OF (b): Generalized Arteriosclerosis — 3 yrs

DUE TO, OR AS A CONSEQUENCE OF (c): —

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. I **certify** that (I) (this hospital) attended the deceased from 6-6, 1962, to 2-13, 1969, that (I) (we) last saw the deceased alive on 2-12-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Neil R. Taylor Jr. M.D. — DEGREE: ATTENDING PHYS. [X] MED DIRECTOR [ ] STAFF PHYS. [ ] — 22c. DATE SIGNED: 2-14-69

22d. PHYSICIAN'S NAME (Type): Neil R. Taylor Jr. M.D. — 22e. ADDRESS: Rising Sun, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 2--15--69	23c. NAME OF CEMETERY OR CREMATORY: Brookview Cem.	23d. LOCATION (City or Town): Rising Sun	(County): Cecil	(State): Md.
24. FUNERAL DIRECTOR: Edmond M. Muller Jr.	ADDRESS: Rising Sun, Md.	25a. REC'D BY REGISTRAR DATE: FEB 17 1969	25b. REGISTRAR'S SIGNATURE		

1

02287

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02283

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Edna	Hannah	Freeman	Feb 16 1969	4:46 P.M.

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN
Female	negro	June 14, 1906	62 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Coatesville, Pa.	United States	MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	Cecil Md

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
Port Deposit	Box 118 Route 1 Port Deposit	House wife	

13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Port Deposit	Cecil	Port Deposit	YES ☐ NO ☒	Box 118 Route 1

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Marshall		Pernsley	Sarah	Rosetta	Pernsley

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17. INFORMANT Address
No	None	Rev St Paul Freeman Port Deposit Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Cerebral accident — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4 hrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b) Arteria Sclerosis, Hypertension — 3 yrs

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Myocarditis, Diabetes

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that (I) (this hospital) attended the deceased from Jan 5, 1969, to Feb 16, 1969, that (I) (we) last saw the deceased alive on Feb 16 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Clarence J. Benson	MD		☒	☐	2/15/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
CLARENCE J. BENSON	Port Deposit, Md

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	2-25-69	Chestnut Grove Amb.	Chester PA

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
George W Tittle Bel Air Md	FEB 27 1969	J Charles Judge

VR A15 (4)
30M REV 1/68

4 1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02288

CERTIFICATE OF DEATH

02284

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Amanda	-------	Gambill	Feb. 24 1969	12:30 P.M.

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
Female	White	9--15--1891	77 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
N.C.	U. S. A.		Cecil Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
North East R.D.	North East R. D.	Housewife Ret.	Own Home

13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER
Md.	Cecil	N. East R.D.		North East R.F.D.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
William	-----	Brooks	Sally	--------	Baugess

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17. INFORMANT	Address
No			Dean Gambill	North East, R.F.D.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) Congestive Heart Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 months
DUE TO, OR AS A CONSEQUENCE OF
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4210
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Diabetes

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS ☐	MED. DIRECTOR ☐	STAFF PHYS ☐	22c. DATE SIGNED
F.B. Robinson M.D.					Feb 26 69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
F.B. Robinson M.D.	Oxford Pa

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
Burial	2-27-1969	Conowingo Baptist	Conowingo	Cecil	Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Lemon & McMullen	Rising Sun Md.	MAR 3 1969	Clarence Young

VR A15
30M REV.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02289 02285

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED-NAME (Type or print) First: JOSEPH	Middle: ALFRED	Last: GODESKY	2a. DATE OF DEATH: February Month 5 Day 1969 Year
2b. HOUR: 3:35a M			
3 SEX: Male	4 RACE: White	5 DATE OF BIRTH: May 31, 1919	6 AGE (In years last birthday): 49 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.		
7a BIRTHPLACE (State or foreign country): New Jersey	7b CITIZEN OF WHAT COUNTRY?: USA	8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9 COUNTY OF DEATH: Cecil Md
10 CITY OR TOWN OF DEATH: Perry Point	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Veterans Administration	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Molder	12b KIND OF BUSINESS OR INDUSTRY: Iron Fndry
13a USUAL RESIDENCE (Where deceased lived before admission) STATE: New Jersey	13b COUNTY: Hudson	13c CITY OR TOWN: Bayonne	13d INSIDE CITY LIMITS? YES ☒ NO ☐
13e STREET AND NUMBER: 52 Newman Avenue			
14 FATHER'S NAME First Middle Last: Steven Godesky	15 MOTHER'S MAIDEN NAME First Middle Last: Mary Kotarski		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or Unknown: Yes	(If yes give war or dates of service): WWII	16b. SOCIAL SECURITY NO: 144-07-4624	17. INFORMANT Address: VA Hospital Records, Perry Point, Md.

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Bronchopneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b):
DUE TO, OR AS A CONSEQUENCE OF
(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d INJURY OCCURRED While at work ☐ Not while at work ☐	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No. City or Town County State	

22a. I certify that (X) (this hospital) attended the deceased from April 11, 1968, to Feb. 5, 1969, ~~xxxx (x) (we) last saw the deceased alive on xxxxxxxxxxxxxxxx 19xxx~~ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) ~~(did not)~~ view the body after death

22b SIGNATURE: [signature] DEGREE: ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☒ — 22c DATE SIGNED: Feb. 5, 1969

22d PHYSICIAN'S NAME (Type): SEMOUR GOLDGRABEN, M.D. — 22e ADDRESS: VA Hospital, Perry Point, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial	23b DATE: Jan. 8, 1969	23c NAME OF CEMETERY OR CREMATORY: ~~Holy Cross~~ Mt. Calvary	23d LOCATION (City or Town): ~~North Arlington~~ LANSDOWNE	(County)	(State): N.J.
24 FUNERAL DIRECTOR: Grant Funeral Home [Paul R. Crouch]	ADDRESS: Box 22 North East, Md.	25a REC'D BY REGISTRAR: FEB 6 1969	25b REGISTRAR'S SIGNATURE: [Charles Judge]		

VR A15 (4) 45M 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02290 02286

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

1. DECEASED-NAME (Type or print)	First: Marian	Middle: T.	Last: Godman	2a. DATE OF DEATH Month: 2	Day: 24	Year: 1969	2b. HOUR: 11:00 A
3. SEX: Female	4. RACE: Cau.	5. DATE OF BIRTH: Dec. 22, 1894	6. AGE (In years last birthday): 74 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.		
7a. BIRTHPLACE (State or foreign country): Kentucky	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Cecil Md				
10. CITY OR TOWN OF DEATH: Carpenters Point	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): R.F.D.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): House Wife	12b. KIND OF BUSINESS OR INDUSTRY: ----				
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE: Maryland	13b. COUNTY: Cecil	13c. CITY OR TOWN: Pt. Carpenters	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET AND NUMBER: R.F.D.			
14. FATHER'S NAME First: James	Middle: H.	Last: Tinsley	15. MOTHER'S MAIDEN NAME First: Elizabeth	Middle:	Last: Pogue		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or Unknown: No (If yes give war or dates of service): ----	16b. SOCIAL SECURITY NO.: Unknown	17. INFORMANT: Marshall L. Godman	Address: Carpenters Point, Md.				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a): Chronic Myocarditis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4 yr

DUE TO, OR AS A CONSEQUENCE OF

(b): Arthritis Deformans — 20 yr

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from Aug — 1968 to Feb 24 1969, that (I) (we) last saw the deceased alive on Feb 24 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS	MED. DIRECTOR	STAFF PHYS	22c. DATE SIGNED
Clarence I. Benson	M.D.		[X]	[ ]	2/25/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Clarence I. Benson M.D.	Box 123 - Port Deposit, Md

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
Burial	2/27/1969	Green Lawn Cemetery	Columbus		Ohio

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Lee A. Patterson & Son	Perryville, Md.	MAR 3 1969	[illegible]

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02291 — 02287

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First: BOOKER	Middle: T.	Last: HARPER	2a. DATE OF DEATH Month: 2 Day: 19 Year: 69	2b. HOUR: 10:55 am PM	
3. SEX: Male	4. RACE: Negro	5. DATE OF BIRTH: 11-20-19	6. AGE (In years last birthday): 49 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country): Dew West, S.C.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Cecil Md			
10. CITY OR TOWN OF DEATH: Perry Point	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Veterans Administration	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE: District of Columbia	13b. COUNTY	13c. CITY OR TOWN: Washington	13d. INSIDE CITY LIMITS? YES [ ] NO [ ]	13e. STREET AND NUMBER: 450A Condon Terrace, SE		
14. FATHER'S NAME First: John	Middle	Last: Booler (D)	15. MOTHER'S MAIDEN NAME First: Marie	Middle	Last: Harper	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes	(If yes give war or dates of service): WW II	16b. SOCIAL SECURITY NO: 254-42-4092	17. INFORMANT: VA Hospital Records	Address: Perry Point, Md.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cerebral thrombosis acute.
DUE TO, OR AS A CONSEQUENCE OF
(b): Hypertensive cardiovascular disease.
DUE TO, OR AS A CONSEQUENCE OF
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County / State

22a. **I certify** that (I) (this hospital) attended the deceased from Feb. 12, 19 69, to Feb. 19, 19 69 xxxxxxxxx. That (I) (we) last saw the deceased alive xxxxxxxxxxxxxxxxxxxxxxxxxxxx, 19xxx and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Irina Reus MD	DEGREE	ATTENDING PHYS. [ ]	MED DIRECTOR [ ]	STAFF PHYS. [X]	22c. DATE SIGNED: 2-19-69
22d. PHYSICIAN'S NAME (Type): IRINA REUS MD.		22e. ADDRESS: VA Hospital, Perry Point, Md.			

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE: 2/22/69	23c. NAME OF CEMETERY OR CREMATORY: Ware Shoal SC	23d. LOCATION (City or Town)	(County)	(State)
24. FUNERAL DIRECTOR: Hall Bros - HALL BROTHERS FUNERAL HOME	ADDRESS: 621 Fla. Ave. NW Wash D.C.	25a. RECD BY REGISTRAR DATE: FEB 24 1969	25b. REGISTRAR'S SIGNATURE: [illegible]		

VR A15 (4) 45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02293 Item 8 Film 409 2/10/69 kk

02288

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

1 DECEASED-NAME (Type or print)	First: Walter	Middle: S.	Last: HICKMAN	2a. DATE OF DEATH Month: Feb. Day: 12, Year: 1969	2b. HOUR: 12:50 M	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: 7-24-93	6. AGE (In years last birthday): 75 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Cecil Md.			
10. CITY OR TOWN OF DEATH: Perry Point	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): VA Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if ret'd.): Farm & Various	12b. KIND OF BUSINESS OR INDUSTRY: Labor			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: Maryland	13b. COUNTY: Kent	13c. CITY OR TOWN: Chestertown	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: 619 W Cannt St.,		
14 FATHER'S NAME First: Stephen	Middle	Last: Hickman (D)	15. MOTHER'S MAIDEN NAME First: Mary	Middle	Last: Jewell (D)	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes	(If yes give war or dates of service): WW I	16b. SOCIAL SECURITY NO: 212-12-23-36	17. INFORMANT: VA Hospital Records - Perry Point, Maryland	Address		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Bronchopneumonia, bilateral	
DUE TO, OR AS A CONSEQUENCE OF (b)	Carcinoma of skin of right forehead with	
DUE TO, OR AS A CONSEQUENCE OF (c)	generalized metastasis	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [X] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** that I (X) (this hospital) attended the deceased from 12-30-68, 19____, to 2-12-69, 19____, ~~that (I) (we) last~~ ~~saw the deceased alive on the~~ ~~18~~, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: A. L. Mooney, M.D.	DEGREE	ATTENDING PHYS. [ ]	MED DIRECTOR [ ]	STAFF PHYS. [X]	22c. DATE SIGNED: 2-12-69
22d. PHYSICIAN'S NAME (Type): A. L. MOONEY, M.D.	22e. ADDRESS: VA Hospital - Perry Point, Maryland				

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 2/15/69	23c. NAME OF CEMETERY OR CREMATORY: Chester Cemetery	23d. LOCATION (City or Town) (County) (State): Chestertown, Maryland	
24. FUNERAL DIRECTOR: Willis Wells	ADDRESS: WILLIS WELLS Funeral Home - Chestertown, Md.	25a. REC'D BY REGISTRAR DATE: FEB 17 1969	25b. REGISTRAR'S SIGNATURE	

VR A15 (4) 45M - 1-69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02293 — 02289

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

VR A15 45M 1-68

1. DECEASED-NAME (Type or print) First	Ollie	Middle Mae	Last Ingram
2a. DATE OF DEATH Month Day Year	2 - 22 - 1969	2b. HOUR	4:05 P.M.
3. SEX	Female		
4. RACE	White		
5. DATE OF BIRTH	Feb. Jan. 17, 1924		
6. AGE (In years last birthday)	45 YRS	If under 1 year: Months / Days	If under 24 hrs: Hours / Min
7a. BIRTHPLACE (State or foreign country)	Shouns, Tenn.		
7b. CITIZEN OF WHAT COUNTRY?	U.S.A.		
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]			
9. COUNTY OF DEATH	Cecil Md		
10. CITY OR TOWN OF DEATH	Elkton		
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	Union Hospital		
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	Housewife		
12b. KIND OF BUSINESS OR INDUSTRY	AT HOME		
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE	Md.		
13b. COUNTY	Cecil		
13c. CITY OR TOWN	Elkton		
13d. INSIDE CITY LIMITS? YES [X] NO [ ]			
13e. STREET AND NUMBER	132½ Maffitt Street		
14. FATHER'S NAME First	Clifford	Middle	Last Willen
15. MOTHER'S MAIDEN NAME First	no information	Middle	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	no		
16b. SOCIAL SECURITY NO	221-14-7275		
17. INFORMANT Address	Ralph Ingram 132½ Maffitt St., Elkton, Md.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY:

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (a)	CONGESTIVE HEART FAILURE	5 days
DUE TO, OR AS A CONSEQUENCE OF (b)	MYOCARDIAL INFARCTION	3 days.
DUE TO OR AS A CONSEQUENCE OF (c)	CORONARY THROMBOSES	4 days

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** that (I) (~~this physician~~) attended the deceased from Feb. 13, 1969, to Feb. 22, 1969, that (I) (~~we~~) last saw the deceased alive on Feb. 22, 1969, and that in (my) (~~our~~) opinion death occurred at the date and hour and from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE	Rolando A. Najera, M.D.	DEGREE: ATTENDING PHYS [X] MED DIRECTOR [ ] STAFF PHYS. [ ]	22c. DATE SIGNED 2/24/69
22d. PHYSICIAN'S NAME (Type)	Rolando A. Najera, M.D.	22e. ADDRESS	105 E. Main St., Elkton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	Burial	23b. DATE	Feb. 26, 1969	23c. NAME OF CEMETERY OR CREMATORY	Elkton Cemetery
23d. LOCATION (City or Town) (County) (State)	Elkton	Cecil	Md.		
24. FUNERAL DIRECTOR	PIPPIN FUNERAL HOME	ADDRESS	Elkton, Md.	25a. FILED BY REGISTRAR DATE	FEB 27 1969
25b. REGISTRAR'S SIGNATURE					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1-69

02294

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02290

1 DECEASED NAME (Type or print) First: Adeline	Middle: Reba	Last: McCall	2a DATE OF DEATH Month: Feb. Day: 22 Year: 1969	2b HOUR: 5:35 A.M.
3 SEX: Female	4. RACE: White	5. DATE OF BIRTH: Oct. 12, 1889	6 AGE (In years last birthday): 79 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN
7a BIRTHPLACE (State or foreign country): Maryland	7b CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Cecil Md.	
10 CITY OR TOWN OF DEATH: North East	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): R.D. # 2	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Homemaker	12b KIND OF BUSINESS OR INDUSTRY: Home	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: Maryland	13b COUNTY: Cecil	13c CITY OR TOWN: Charlestown	13d INSIDE CITY LIMITS? YES ☒ NO ☐	13e STREET AND NUMBER:
14. FATHER'S NAME First: Lewis	Middle: A.	Last: McCall	15. MOTHER'S MAIDEN NAME First: Carrie	Middle:	Last: Clark
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16b SOCIAL SECURITY NO: 215-56-1241	17 INFORMANT: Nellie V. McCall	Address: Charlestown, Md.	

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a) Cardio Vascular Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 30 min.

4122

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) C.V.A. - Cerebral Hemorrhage — 4 wks.

DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension- H.C.V.D. — years

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

G.A.S.C. - A.S.C.V.D., Fractured Hip, Large Bed Sores.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)
21d. INJURY OCCURRED While ☐ at work Not while ☐ at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f LOCATION Street or R.F.D. No / City or Town / County / State

22a. I **certify** that (I) (this hospital) attended the deceased from Jan. 8, 1969, to Feb. 22, 1969, that (I) (we) last saw the deceased alive on Feb. 21 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS	22c DATE SIGNED
Luis M. Cuza M.D.	M.D.	☒	☐	☐	Feb. 24, 1969

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Luis M. Cuza M.D.	322 E. Cecil Ave. North East, Md.

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	2-26-69	North East Methodist	North East Cecil Md.

24 FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Grant Funeral Home Paul A. Grant	Box 22 North East, Md.	FEB 26 1969	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02295

CERTIFICATE OF DEATH

02292

1 DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
Arthur	D.	Moon	Feb	8	1969	6 P M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Male	White	Mar. 10, 1883	85 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
Md.	U.S.A.		Cecil Md.

10. CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b KIND OF BUSINESS OR INDUSTRY
Elkton	Union Hospital	Engineer	Railroad

13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER
Md.	Cecil	North East	YES ☒ NO ☐	108 E. Cecil Ave.

14 FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last
John	H.	Moon	Clara	A.	Lake

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17 INFORMANT	Address
No	716-12-7092	Elizabeth B. McMullen	Charlestown, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute myocardial infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO, OR AS A CONSEQUENCE OF

(b) Arteriosclerotic cardiovascular disease — 5 yrs.

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 7109

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 1-8, 19 69, to 2-8, 19 69, that (I) (we) lost saw the deceased alive on 2-8 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Jay S. Barnhart Jr.		☒	☐	☐	2-10-69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Jay S. Barnhart Jr.	4 Mauldin Ave North East, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	2-12-69	Cathedral Cemetery	Wilmington, New Castle Del.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Grant Funeral Home Paul R. Crouch	North East, Md	FEB 13 1969	J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

Item 18 Film 409 2-18

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02296

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02292

1. DECEASED-NAME (Type or Print) First	Middle	Last	2a DATE KNOWN OF DEATH ESTIMATED	Month	Day	Year	2b HOUR
HARRY	SHELTON	OSBORNE	X	2	11	1969	5:35 P

3. SEX	4. RACE	5 DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN	2c DATE PRONOUNCED DEAD Month Day Year	2d. HOUR
Male	White	Jan. 27, 1914	55 YRS			February 11, 1969	5:35 P

7a BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9 COUNTY OF DEATH
Tennessee	U.S.A.		Cecil Md.

10. CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b KIND OF BUSINESS OR INDUSTRY
Elkton	Union Hospital	Carpenter	Building

13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b COUNTY	13c. CITY OR TOWN	13d INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Cecil	Elkton	YES ☐ NO XX	R. D. 4, Andora

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Henson		Osborne	Inez		Shupe

16a. WAS DECEASED EVER IN U.S ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17 INFORMANT	ADDRESS
No	232-18-1245	Mrs. Ella Mae Osborne, Elkton, Md.	R.D. # 4

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Fatty Liver Acute alcoholism	
DUE TO, OR AS A CONSEQUENCE OF		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		
DUE TO, OR AS A CONSEQUENCE OF		
(c)		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES XX NO ☐

21a EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R F D No	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held an Autopsy XX Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes XX, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Edward F. Wilson M.D.

EXAMINER'S NAME (Type) Edward F. Wilson, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER XX
DEPUTY MEDICAL EXAMINER ☐
ADDRESS(Street, city, town, or county)

22b DATE SIGNED 2/12/69

23a BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	2/15/69	Gilpin Manor Memorial Park,	Elkton, Md.

24. FUNERAL DIRECTOR ADDRESS	25a DEPUTY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
Ralph E. Hicks Hicks Home for Funerals, Elkton, Md.	FEB 18 1969	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the ward 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form HMS Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV. 1/68

1

02297 - 02293

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First: Arthur	Middle: S.	Last: REISHER
2a. DATE OF DEATH	Month: February	Day: 7,	Year: 1969
2b. HOUR	M
3. SEX	Male
4. RACE	White
5. DATE OF BIRTH	5-31-96
6. AGE (In years last birthday)	72 YRS
IF UNDER 1 YEAR: MONTHS / DAYS	
IF UNDER 24 HRS: HOURS / MIN	
7a. BIRTHPLACE (State or foreign country)	Penna.
7b. CITIZEN OF WHAT COUNTRY?	U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	
9. COUNTY OF DEATH	Cecil Md
10. CITY OR TOWN OF DEATH	Perry Point
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	VA Hospital
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	Shoemaker
12b. KIND OF BUSINESS OR INDUSTRY	Shoemaking
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	Maryland
13b. COUNTY	
13c. CITY OR TOWN	Hagerstown
13d. INSIDE CITY LIMITS? YES ☒ NO ☐	
13e. STREET AND NUMBER	719 George St.,
14. FATHER'S NAME First / Middle / Last	
15. MOTHER'S MAIDEN NAME First / Middle / Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	Yes WW I
16b. SOCIAL SECURITY NO.	214-09-57-81
17. INFORMANT Address	VA Hospital Records - Perry Point, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

4339

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b) C. V. A. (Cerebral infarction) — 2 months

DUE TO, OR AS A CONSEQUENCE OF (c) Cerebral arteriosclerosis

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. I certify that (I) (this hospital) attended the deceased from 5-3-61, 19 ___, to 2-7-69, 19 ___, that (I) (we) last saw the deceased alive on ___, 19 ___, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	A. L. Mooney, M.D.	DEGREE: ATTENDING PHYS. ☐ MED DIRECTOR ☐ STAFF PHYS. ☒	22c. DATE SIGNED: 2-7-69
22d. PHYSICIAN'S NAME (Type)	A. L. MOONEY, M.D.	22e. ADDRESS	VA Hospital - Perry Point, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County) (State)
Burial	2/10/69	Cedar Grove Cemetery	Chambersburg,	Penna
24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE	
Lee A. Patterson & Son	Perryville, Md.	FEB 14 1969		

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02288 — 02294

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 45M - 1-68

1. DECEASED NAME (Type or print): First: John; Middle: L.; Last: Ryan
2a. DATE OF DEATH: Month: Feb; Day: 9; Year: 1969
2b. HOUR: M
3. SEX: Male
4. RACE: Cau
5. DATE OF BIRTH: March 15, 1898
6. AGE (In years last birthday): 70 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN
7a. BIRTHPLACE (State or foreign country): Delaware
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. COUNTY OF DEATH: Cecil — Md
10. CITY OR TOWN OF DEATH: Elkton
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Union Hospital
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Retired
12b. KIND OF BUSINESS OR INDUSTRY: Carpenter
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE: Maryland
13b. COUNTY: Cecil
13c. CITY OR TOWN: Charlestown
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER:
14. FATHER'S NAME: First: Frank; Middle: B.; Last: Ryan
15. MOTHER'S MAIDEN NAME: First: Kate; Middle: B.; Last: Jackson
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No (If yes give war or dates of service): --
16b. SOCIAL SECURITY NO.: 218-03-9833
17. INFORMANT: Address: J. U. Ryan, Perryville, Maryland.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardio-Vascular Failure	30 Minutes
DUE TO, OR AS A CONSEQUENCE OF (b)	Mediastinal & Lung Metastasis	1 year
DUE TO, OR AS A CONSEQUENCE OF (c)	Bronchogenic Carcinoma	2 years

1621 — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): osteo arthritis - deformant

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☒ NO ☐
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY: HOUR A.M. P.M, Month, Day, Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)
21f. LOCATION: Street or R.F.D. No. | City or Town | County | State

22a. **I certify** that (I) (this hospital) attended the deceased from 9-24, 1954 to 2-9, 1969, that (I) (we) last saw the deceased alive on 2-8-1969, and that to (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Luis M. Cuza MD — DEGREE — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: 2-11-69
22d. PHYSICIAN'S NAME (Type): LUIS M. CUZA, M.D.
22e. ADDRESS: 322 E. Cecil Ave. North East, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 2/11/1969
23c. NAME OF CEMETERY OR CREMATORY: North East Cemetery
23d. LOCATION (City or Town) (County) (State): North East Cecil Md.
24. FUNERAL DIRECTOR: Lee A. Patterson & Son
ADDRESS: Lee A. Patterson & Son, Perryville, Md.
25a. REC'D BY REGISTRAR (DATE): FEB 14 1969
25b. REGISTRAR'S SIGNATURE: [illegible]

4 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02299 02295

1. DECEASED-NAME (Type or print)	First: Joseph	Middle: G. FORD	Last: SCARBOROUGH	2a. DATE OF DEATH: Month February Day 20 Year 1969	2b. HOUR: 4:48 P M		
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: 7-5-11	6. AGE (In years last birthday): 57 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN		
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Cecil Md.				
10. CITY OR TOWN OF DEATH: Perry Point	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): VA Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Lawyer	12b. KIND OF BUSINESS OR INDUSTRY: Law				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Cecil	13c. CITY OR TOWN: Elkton	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: 200 Kentmere Ave.,			
14. FATHER'S NAME First: LEEDOM Middle: J. Last: Scarborough	15. MOTHER'S MAIDEN NAME First: Nelly Middle: Kerr Last:						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: Yes	(If yes give war or dates of service): WW II	16b. SOCIAL SECURITY NO: 213-12-54-34	17. INFORMANT Address: VA Hospital Records - Perry Point, Maryland				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute Cardiac Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Coronary Artery Occlusion, severe

DUE TO, OR AS A CONSEQUENCE OF

(c) Arteriosclerotic Heart Disease with severe sclerosis of Coronary Arteries

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

Diabetes Mellitus

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [X] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I certify that ~~(I)~~ (this hospital) attended the deceased from 7-10-68, 19____, to 2-20-69, 19____ ~~which (I) (we) last saw the deceased alive on 19~~, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS	MED. DIRECTOR	STAFF PHYS	22c. DATE SIGNED
A. L. Mooney, M.D.		[ ]	[ ]	[X]	Feb. 20, 1969

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
A. L. MOONEY, M.D.	VA Hospital - Perry Point, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	2/24/69	FRIENDS CEMETERY	CALVERT CECIL Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Pippin Funeral Home	Pippin Funeral Home, Elkton, Md.	FEB 24 1969	

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02300

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02296

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
Merle	W.	Simpers	Feb.	21	1969	4:00 AM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
male	White	6/7/05	63-64 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Maryland	USA		Cecil County Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
Elkton	Union Hospital	Mail Clerk	Civil Service

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Cecil	North East	YES ☒ NO ☐	407 S. Maryland Ave.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Harry		Simpers	Mary		Devore

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	188-05-1346	Mrs. Bess F. Simpers	407 S. Md. Ave. North East, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) METASTATIC ADENOCARCINOMA of Colon — APPROX. MAYE INTERVAL BETWEEN ONSET AND DEATH: 11 YEARS.

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

1938

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	

21a. ACCIDENT WAS UNDERLYING	21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	HOUR A.M. P.M. Month Day Year 19	

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (At home, farm, street factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) ~~(this hospital)~~ attended the deceased from 8 OCT, 1968, to present, 19____, that (I) ~~(last)~~ saw the deceased alive on 20 Feb, 1969, and that in (my) (opinion) death occurred on the date and hour and from the causes stated above, (I) (~~did~~) (~~did not~~) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS ☒	MED DIRECTOR ☐	STAFF PHYS. ☐	22c. DATE SIGNED
Robert L. Gray	MD				21 Feb 1969.

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Robert L. Gray	123 W. High St. Elkton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	2-25-29	St. Mary Anne's	North East Cecil Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Grant Funeral Home Paul M. Couch	Box 22 North East, Md.	DATE FEB 25 1969	Charles Lindsay

VR A15 (4)
30M REV. 1/68

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02301 — 02294

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Lily	B.	Slade	February 10, 1969	M

3. SEX	4 RACE	5. DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
Female	White	May 12, 1893	75 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
England	U.S.A.		Cecil Md

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Elkton	Union Hospital	Housewife	--

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER
Maryland	Cecil	Elkton	YES ☐ NO ☒	Box 218, R.D. # 3

14 FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Absolom		Joyce	Louisa	Jane	Beaton

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17. INFORMANT Address
No		R.D.# 3 Leonard F. Slade, Elkton, Md. 21921

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute Anterior Myocardial Infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

(b) ASCVD

DUE TO, OR AS A CONSEQUENCE OF

(c)

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

Diabetes Mellitus

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES ☒ NO ☐	Yes

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, nat.fy medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R F D No.	City or Town	County	State

22a. I **certify** that (I) (~~this hospital~~) attended the deceased from ____, 1967, to Present, 19____, that (I) (~~he~~) last saw the deceased alive on 10 Feb 1969, and that in (my) (~~his~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~he~~) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED DIRECTOR	STAFF PHYS	22c. DATE SIGNED
Robert L. Gray	M.D.	☒	☐	☐	14 Feb 1969

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Robert L. Gray	123 W. High St. Elkton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	2/14/69	Gracelawn Memorial Park,	Wilmington, Del.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Ralph E. Hicks Hicks Home for Funerals, Elkton, Md.	FEB 18	

VR A15 (4)
30M REV. 1/68

4 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02302 02298

1. DECEASED-NAME (Type or print) First: JOHN Middle: Wesley Last: SMITH	2a. DATE OF DEATH Month: 2 Day: 27 Year: 69	2b. HOUR: 10:10 P.M.	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: 10-16-07	6. AGE (In years last birthday): 61 YRS. IF UNDER 1 YEAR: MONTHS, DAYS. IF UNDER 24 HRS: HOURS, MIN.
7a. BIRTHPLACE (State or foreign country): Virginia	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Cecil Md.
10. CITY OR TOWN OF DEATH: Perry Point	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Veterans Administration	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Mechanic	12b. KIND OF BUSINESS OR INDUSTRY: auto
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Harford	13c. CITY OR TOWN: Edgewood	13d. INSIDE CITY LIMITS? YES ☐ NO ☒ — 13e. STREET AND NUMBER: 503 Kennard Avenue
14. FATHER'S NAME First: John Henry Middle: Last: Smith (D)	15. MOTHER'S MAIDEN NAME First: Alice Middle: Dyer Last: (D)		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: Yes (If yes give war or dates of service): WW II	16b. SOCIAL SECURITY NO.: 226-72-2409	17. INFORMANT Address: VA Hospital Records, Perry Point, Md.	

MEDICAL CERTIF CAT. O

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia, bilateral
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF (b): Pulmonary emphysema with right side heart failure (Cor pulmonale).
DUE TO, OR AS A CONSEQUENCE OF (c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. I certify that (I) (this hospital) attended the deceased from Feb. 21, 19 69, to Feb. 27, 19 69, that (I) (we) last saw the deceased alive on xxxxxxxxxxxxxxxxxx and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: A. L. Mooney M.D. DEGREE: ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒	22c. DATE SIGNED: 2-27-69		
22d. PHYSICIAN'S NAME (Type): A. L. Mooney, M.D.	22e. ADDRESS: VA Hospital, Perry Point, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 3-3-69	23c. NAME OF CEMETERY OR CREMATORY: Baltimore National Cemetery	23d. LOCATION (City or Town) (County) (State): Baltimore Md.
24. FUNERAL DIRECTOR ADDRESS: McCOMAS Funeral Home Abington, Md.	25a. REC'D BY REGISTRAR DATE: MAR 3 1969	25b. REGISTRAR'S SIGNATURE: Virginia B. Georgia	

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

02303 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02293

1 DECEASED-NAME (Type or Print) First / Middle / Last: Theresa E. Starliper				2a DATE OF DEATH KNOWN [X] ESTIMATED [ ] Month Feb. Day 8 Year 1969	2b HOUR M
3 SEX: Female	4. RACE: White	5 DATE OF BIRTH: Mar. 1, 1902	6 AGE (In years last birthday) 66 YRS; IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN	2c DATE PRONOUNCED DEAD Month Feb. Day 8 Year 1969	2d HOUR 2:20 P.M.
7a. BIRTHPLACE (State or foreign country): Penna.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED [XX] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9 COUNTY OF DEATH: Cecil Md.		
10. CITY OR TOWN OF DEATH: Elkton	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Union Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife	12b KIND OF BUSINESS OR INDUSTRY: Home		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: Penna.	13b. COUNTY: Delaware	13c CITY OR TOWN: Morton	13d INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET AND NUMBER: 409 Highland Ave.	
14. FATHER'S NAME First / Middle / Last: John Eberwine		15. MOTHER'S MAIDEN NAME First / Middle / Last: Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO: 204-07-6408	17. INFORMANT: William D. Starliper	ADDRESS: Morton, Penna.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)

PART I DEATH WAS CAUSED BY — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION

DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY THROMBOSES — 20-30 min.

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last — 4109

DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROTIC CARDIOVASCULAR DIS. — 7 years.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES [ ] NO [X]
21a EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No. / City or Town / County / State

22a. I **certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Rolando A. Najera M.D.

EXAMINER'S NAME (Type): Rolando A. Najera, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [ ]
ADDRESS (Street, city, town, or county)

22b. DATE SIGNED: Feb. 8, 1969

23a BURIAL, CREMATION, REMOVAL (Specify): Burial	23b DATE: Feb. 12, 1969	23c NAME OF CEMETERY OR CREMATORY: St. Peter & Paul	23d LOCATION (City or Town) (County) (State): Springfield Delaware Penna.	
24 FUNERAL DIRECTOR: Grant Funeral Home — Paul R. Crouch	ADDRESS: North East, Md.	25a RECD BY REGISTRAR DATE: FEB 11 1969	25b REGISTRAR'S SIGNATURE	

VR A15ME (5) 1DM REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02304

CERTIFICATE OF DEATH

02300

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY CECIL MARYLAND b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RISING SUN c LENGTH OF STAY IN 1b 10 YRS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY CECIL c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RISING SUN (RURAL) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First WINIFRED	Middle PUGH	Last STUART	4 DATE OF DEATH	Month FEB.	Day 13	Year 1969	
5 SEX FEMALE	6 COLOR OR RACE WHITE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8 DATE OF BIRTH JAN. 15, 1893	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min		

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE	10b KIND OF BUSINESS OR INDUSTRY HOME	11 BIRTHPLACE (County & State or foreign country) VIRGINIA	12 CITIZEN OF WHAT COUNTRY? U.S.A.
13 FATHER'S NAME WILLIAM R. PUGH		14. MOTHER'S MAIDEN NAME ELEANOR MOORE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)	16. SOCIAL SECURITY NO 219-10-3139	17. INFORMANT Address MRS JAMES LAWSON JR. RISING SUN, MD.	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Myocardial infarction	2 days
DUE TO (b)	Arteriosclerotic heart disease	5 yrs.
DUE TO (c)		

4109

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 6-1, 1968, to 2-13, 1969, that (I) (we) last saw the deceased alive on 2-12, 1969, and that death occurred at 9A M, from causes and on the date stated above.

22a. SIGNATURE Neil R Taylor Jr M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐		22b. DATE SIGNED 2-13-69
22c. PHYSICIAN'S NAME (Type) Neil R Taylor Jr	22d. ADDRESS	

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF FEB. 16, 1969	23c NAME OF CEMETERY OR CREMATORY BROOKVIEW	23d. LOCATION (City or Town) RISING SUN,	(County) CECIL, (State) MD
24. FUNERAL DIRECTOR Ralph M. Reed RALPH M. REED	ADDRESS RISING SUN, MD.	25a REC'D BY REGISTRAR DATE FEB 17 1969	25b. REGISTRAR'S SIGNATURE	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

02305 02301

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 2 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First / Middle / Last: Josephine E. Wardell			2a. DATE OF DEATH Month / Day / Year: Feb. 8 1969	2b. HOUR: 4:18 P.M.
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: Oct. 12, 1892	6. AGE (In years last birthday): 76 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): Delaware	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Cecil Md.	
10. CITY OR TOWN OF DEATH: Elkton	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Union Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Cecil	13c. CITY OR TOWN: North East	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 215 S. Main St.
14. FATHER'S NAME First / Middle / Last: Harry C. Milbourne		15. MOTHER'S MAIDEN NAME First / Middle / Last: Sophia Payne		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service):	17. INFORMANT: Harry T. Milbourne	Address: 4200 Verona Dr. Wilmington 8, Del.	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): METASTATIC ADENOCARCINOMA BREAST — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 years.
DUE TO, OR AS A CONSEQUENCE OF
(b):
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 174 X

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that (I) (~~this hospital~~) attended the deceased from _____, 1963, to Present, 19____, that (I) (~~was~~) last saw the deceased alive on 7 Feb 1969, and that in (my) (~~his~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~was~~) (~~did~~) (did not) view the body after death.

22b. SIGNATURE					22c. DATE SIGNED
Robert L. Gray M.D	DEGREE	ATTENDING PHYS. ☒	MED. DIRECTOR ☐	STAFF PHYS. ☐	10 Feb 1969.
22d. PHYSICIAN'S NAME (Type): Robert L. Gray		22e. ADDRESS: 123 W. High St. Elkton, Md.			

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: Feb. 11, 1969	23c. NAME OF CEMETERY OR CREMATORY: St. Barnabas	23d. LOCATION (City or Town) (County) (State): Marshallton New Castle Del.
24. FUNERAL DIRECTOR: Grant Funeral Home	ADDRESS: Box 22 North East, Md.	25a. REC'D BY REGISTRAR DATE: FEB 13 1969	25b. REGISTRAR'S SIGNATURE: J. Charles Jones

VR A15 (4) 45M - 1/69

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02306

CERTIFICATE OF DEATH

02302
Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. **TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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15M 9/55

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2

1

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Warwick
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Warwick
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Emma — Middle: P. — Last: Williams

4. DATE OF DEATH: Month: Feb — Day: 1 — Year: 1969

5. SEX: Female

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Mar 4, 1891

9. AGE (In years last birthday): 77 yrs.

IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Charles Pope

14. MOTHER'S MAIDEN NAME: Rose Hoover

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Walter Williams — Address: Warwick, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

4100

IMMEDIATE CAUSE (a): Coronary Embolism — Interval between onset and death: 1day

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Coronary Artery Disease — 2 years

DUE TO

(c) Chronic Hypertention — 11 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan. 15, 1957, to Feb. 1, 1969, that I last saw the deceased alive on Feb. 1, 1969, and that death occurred at 3.45P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Allan R. Cruchley M.D.

ADDRESS (Street, city or town, state):

DATE SIGNED: 2-4-69

PHYSICIAN'S NAME (Type): Allan R. Cruchley, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: Feb 5, 1969

22c. NAME OF CEMETERY OR CREMATORY: Old Bohemia Cem.

22d. LOCATION (City, town, or county) (State): Warwick - Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J. Lester Dandy

ADDRESS: Middletown Del.

24a. REC'D BY REGISTRAR DATE: FEB 7 1969

24b. REGISTRAR'S SIGNATURE: Charles Judge